Exhibit A

Doc Type: 7104

Department Use Only:	Date Received:	OIG	EPLS	DMF	ATN
		☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
FACILITY PROVIDER ENROLLMENT APPLICATION

A. Applicant Base Information

NPI #:* 6050

Legal Business Name: ALLIANCE FOR CHANGE THROUGH TREATMENT, LLC

"Doing Business As" Name: N/A

Type of Facility: (see instructions for list of valid values) 6

State Where Incorporated: GEORGIA

Does this organization operate other sites, locations, or units? ☐ No ☑ Yes

If YES, where? 118 NORTH AVENUE #E, JONESBORO, GA 30236

B. Address Information

1. Service Location (Physical) Address*

Name of Practice: (if applicable) Alliance for Change through Treatment, LLC

Street Address:* (PO Box NOT Acceptable) 3547 Habersham at Northlake

Suite:

City:* TUCKER | County:* DeKalb | State:* GA | Zip +4:* 30084-4009

Office Phone:* 678-406-9707 | Office Fax: 678-406-9881 | After-Hours Phone: 678-406-9707

Office Email: (if available) @mentalhealthgeorgia.com | Office Website: (if available) www.mentalhealthgeorgia.com

Is this location open 24 hours? ☐ Yes ☑ No (ON-CALL) Is this location TDD/TTY equipped? ☐ Yes ☑ No

2. Payee Designation*

Enter the Legal Business Name, Georgia Medicaid Payee ID (if known), and Tax ID numbers associated with the practice the applicant will be rendering services for. This Payee ID can be found on the top right corner of the existing Payee's Remittance Advice. If a Payee number has NOT been established, please write the Legal Business name (as shown on your IRS tax documentation) and Tax ID Number below. Tax ID number must be on the application or it will be returned. You may leave the Payee ID field blank. Form W-9, EFT Agreement, and IRS Tax ID verification (147-C, CP575-A, etc. available from the IRS) are required supporting documents and a new Payee ID will be created as part of the enrollment process.

Payee Legal Business Name:* Alliance for Change through Treatment, LLC | Payee ID Number: 294A | Tax ID Number:* 9086

3. Correspondence Address

Check N/A if correspondence address is the same as the physical address listed on this application ☑ N/A

ATTN TO: (if applicable)

Street Address/ PO Box: 3547 Habersham at Northlake

Suite:

City: TUCKER | County: DeKalb | State: GA | Zip +4: 30084-

Phone: 678-406-9707 | Fax: 678-406-9881 | After-Hours Phone: 678-406-9707

Email: (if available) @mentalhealthgeorgia.com | Website: (if available) www.mentalhealthgeorgia.com

4. Person to Contact in Regards to this Application*

☑ Same as Above

Contact Person's Name (Last): Atkinson | First: Jeffrey | MI: E

Title: Managing Partner/CFO | Telephone Number: 678-406-9707 | Fax Number: 678-406-9881

Email Address: @mentalhealthgeorgia.com

C. Program Enrollment Information (see Instructions for valid code values)

Provider Type Code:* (see instructions)			Specialty Code:* (see instructions)	
10	a. Contract Code:* (see instructions)	442	Specialty Code:	560
	b. Contract Code:		Specialty Code:	
	c. Contract Code:		Specialty Code:	

Dialysis-Technical (Contract 720) Applicants ONLY: Will the services rendered at the Service Location Address provided on this application be performed at a Hospital-Based facility? If NO, then CLIA Certification and Medicare Certification are REQUIRED supporting documents for this application. ☐ Yes ☑ No

DME (Contract 320) Applicants ONLY: Will the applicant provide Custom Wheelchairs? If YES, then Custom Wheelchair Certification is a REQUIRED supporting document for this application. ☐ Yes ☑ No

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D. Licensure

Licensing Entity*: N/A

License Number *:	State*:	Effective Date*:	Expiration Date*:
N/A	N/A	N/A	N/A

Do You Have Any Public Board Orders?* ☐ Yes ☑ No — If Yes, Date of Last Order:

E. Certification – Attach additional sheets, if necessary ☑ N/A

Certifying Entity 1: N/A

Certificate Number:	State:	Effective Date:	Expiration Date:
N/A	N/A	N/A	N/A

Certifying Entity 2: N/A

Certificate Number:	State:	Effective Date:	Expiration Date:
N/A	N/A	N/A	N/A

Medicare Provider Number:	Effective Date:	Expiration Date:
N/A	N/A	N/A

Medicare Carrier / Intermediary Name: ☐ N/A N/A ☐ Part A ☐ Part B

Liability Insurance Amount (Include Copy of Certificate): ☐ N/A HPSO & ACORD

CLIA Number: (If number entered, please include certificate)	Effective Date:	Expiration Date:
N/A		

Providers who possess DEA permits are required to provide a copy of the certificate with the enrollment application. ☑ N/A

DEA Number:	Effective Date:	Expiration Date:
N/A		

All Schedules? (2, 2N, 3, 3N, 4, 5) ☐ Yes ☐ No

F. Other Medicaid Programs* ☑ N/A

1) Medicaid ID Number:	State:	Current Status: ☐ Active ☐ Inactive
Type of Service:	Effective Date:	End Date:
End Date Reason:		
2) Medicaid ID Number:	State:	Current Status: ☐ Active ☐ Inactive
Type of Service:	Effective Date:	End Date:
End Date Reason:		
3) Medicaid ID Number:	State:	Current Status: ☐ Active ☐ Inactive
Type of Service:	Effective Date:	End Date:
End Date Reason:		

G. Languages – List all languages spoken by the Provider.

Primary:	2.	3.
ENGLISH		

H. Other Information ☑ N/A

Licensed Beds:	Available Total Beds:	
N/A	N/A	
Male: N/A	Female: N/A	Either: N/A

I. Practice Type (Select ONLY One) *

☐ Corporation
☑ Group Practice (PRIVATE)
☐ Hospital-Based Physician
☐ Individual Practitioner
☐ Public Clinics
☐ Health Maintenance Organization
☐ Partnership or Professional Organization
☐ Pre-Paid Group Practice Plan
☐ Teaching Provider
☐ Not Applicable
☐ Other:

J. Correspondence Medium *

a. Letter Medium	☐ Paper	☑ Email Link	☐ Fax	☐ Web Portal Message Center
b. Bulletin Medium	☑ Paper	☐ Web Portal Message Center		
c. Remit Medium	☐ Paper	☑ Web Portal Message Center	☐ X-12-835 via Clearinghouse	
d. Billing Medium	☐ Paper	☐ Batch	☑ Web Portal Message Center	☐ PES*

PES requires special software which is available through HPES, EDI Services. For more information call (866) 261-8785

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All fields marked with * are REQUIRED

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K. Managing Relationships*

As required by 42 CFR 1002.3, providers must disclose the following for each individual officer, director, agent, managing employee (general manager, business manager, administrator), and Electronic Funds Transfer (EFT) authorized individual. Failure to provide the required information may result in a denial for participation.

In addition to yourself, do you have any managing relationships? * ☑ Yes ☐ No If yes, list all below

1.	Full Name (Last, First, Middle) * Johnson-Landry, Cassandra		Date of Birth (MM/DD/CCYY) * 1967
Social Security Number * -5102	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc) * None		
Business Relationship to Enrolling Provider (Title) * CEO, managing partner	DEPT USE ONLY→	POA ID:	
2.	Full Name (Last, First, Middle) * Atkinson, Jeffrey Eugene		Date of Birth (MM/DD/CCYY) * 1966
Social Security Number * -5171	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc) * None		
Business Relationship to Enrolling Provider (Title) * CFO, managing partner	DEPT USE ONLY→	POA ID:	
3.	Full Name (Last, First, Middle) *		Date of Birth (MM/DD/CCYY) *
Social Security Number *	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc) *		
Business Relationship to Enrolling Provider (Title) *	DEPT USE ONLY→	POA ID:	
4.	Full Name (Last, First, Middle) *		Date of Birth (MM/DD/CCYY) *
Social Security Number *	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc) *		
Business Relationship to Enrolling Provider (Title) *	DEPT USE ONLY→	POA ID:	
5.	Full Name (Last, First, Middle) *		Date of Birth (MM/DD/CCYY) *
Social Security Number *	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc) *		
Business Relationship to Enrolling Provider (Title) *	DEPT USE ONLY→	POA ID:	
6.	Full Name (Last, First, Middle) *		Date of Birth (MM/DD/CCYY) *
Social Security Number *	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc) *		
Business Relationship to Enrolling Provider (Title) *	DEPT USE ONLY→	POA ID:	
7.	Full Name (Last, First, Middle) *		Date of Birth (MM/DD/CCYY) *
Social Security Number *	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc) *		
Business Relationship to Enrolling Provider (Title) *	DEPT USE ONLY→	POA ID:	
8.	Full Name (Last, First, Middle) *		Date of Birth (MM/DD/CCYY) *
Social Security Number *	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc) *		
Business Relationship to Enrolling Provider (Title) *	DEPT USE ONLY→	POA ID:	
9.	Full Name (Last, First, Middle) *		Date of Birth (MM/DD/CCYY) *
Social Security Number *	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc) *		
Business Relationship to Enrolling Provider (Title) *	DEPT USE ONLY→	POA ID:	
10.	Full Name (Last, First, Middle) *		Date of Birth (MM/DD/CCYY) *
Social Security Number *	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc) *		
Business Relationship to Enrolling Provider (Title) *	DEPT USE ONLY→	POA ID:	

If space is needed for additional Managing Relationships, please include the "Managing Relationships-Additional" form available at www.mmis.georgia.gov in the Provider Enrollment section.

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L. Ownership and Control Information

How would you describe the ownership? (Select ONLY One) *

- ☐ Self (Individual filing under a SSN)
- ☐ Single-Owner LLC
- ☐ Sole Proprietor (Individual filing under an EIN)
- ☑ Partnership
- ☐ Corporation

Corporations, Partnerships, and Sole Proprietors: What percentage of shares / ownership do you have? Cassandra Johnson-Landry 50%, Jeffrey E. Atkinson-50%

Does anyone have direct or indirect ownership or control interest of 5% or more in the organization/entity? * ☐ Yes ☐ No

If you answered yes to the above question you must list ownership information for each owner who owns 5% or more.

1.	Full Name (Last, First, MI) * Johnson-Landry, Cassandra		Date of Birth (MM/DD/CCYY) * .1967
Social Security Number * 5102		Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc) * NONE	
Organizational Owner Name: (If not Individual) N/A		Tax ID: (If different than Applicant) -5102	
Business Relationship to Enrolling Provider (Title) * CEO, managing partner	DEPT USE ONLY→	POA ID:	

Does the owner have ownership or controlling interest in another entity or organization that is enrolled in Georgia Medicaid? * (42 CFR 455.104(b)(3): *The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.)* ☐ Yes ☑ No

If the answer to the above is "Yes", provide the Name of Entity, Street Address, City, State, Zip Code and Percentage of Ownership in the space below. If additional space is needed, please provide these details on a separate sheet.

N/A

2.	Full Name (Last, First, MI) * Atkinson, Jeffrey E.		Date of Birth (MM/DD/CCYY) * 1966
Social Security Number * 5171		Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc) * NONE	
Organizational Owner Name: (If not Individual) N/A		Tax ID: (If different than Applicant) 5171	
Business Relationship to Enrolling Provider (Title) * CFO, managing partner	DEPT USE ONLY→	POA ID:	

Does the owner have ownership or controlling interest in another entity or organization that is enrolled in Georgia Medicaid? * ☐ Yes ☐ No

If the answer to the above is "Yes", provide the Name of Entity, Street Address, City, State, Zip Code and Percentage of Ownership in the space below. If additional space is needed, please provide these details on a separate sheet.

N/A

3.	Full Name (Last, First, MI) *		Date of Birth (MM/DD/CCYY) *
Social Security Number *		Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc) *	
Organizational Owner Name: (If not Individual)		Tax ID: (If different than Applicant)	
Business Relationship to Enrolling Provider (Title) *	DEPT USE ONLY→	POA ID:	

Does the owner have ownership or controlling interest in another entity or organization that is enrolled in Georgia Medicaid? * ☐ Yes ☐ No

If the answer to the above is "Yes", provide the Name of Entity, Street Address, City, State, Zip Code and Percentage of Ownership in the space below. If additional space is needed, please provide these details on a separate sheet.

4.	Full Name (Last, First, MI) *		Date of Birth (MM/DD/CCYY) *
Social Security Number *		Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc) *	
Organizational Owner Name: (If not Individual)		Tax ID: (If different than Applicant)	
Business Relationship to Enrolling Provider (Title) *	DEPT USE ONLY→	POA ID:	

Does the owner have ownership or controlling interest in another entity or organization that is enrolled in Georgia Medicaid? * ☐ Yes ☐ No

If the answer to the above is "Yes", provide the Name of Entity, Street Address, City, State, Zip Code and Percentage of Ownership in the space below. If additional space is needed, please provide these details on a separate sheet.

If space is needed for additional Ownership and Control Individual's Information, please include the "Ownership and Control Information - Additional" form available at www.mmis.georgia.gov in the Provider Enrollment section.

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M. Exclusion / Sanction Information * (Use additional sheets if necessary)

For the following questions, the word "you" and "your" shall mean the enrolling provider, its owners, and its agents in accordance with 42 CFR 455.100; 101; 102; 104; 105; 106 and 42 CFR 1001.1001 et seq.:

* An agent is defined as any person who has been delegated the authority to obligate or act on behalf of a provider. This includes, but is not limited to, managing employees, Board Members and Electronic Funds Transfer (EFT) authorized individuals.
* A managing employee is defined as a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the enrolling provider.
* An entity shall include, but not be limited to, a corporation, limited liability company, partnership, business, provider organization, or professional association.

Note: All applicable adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.

1. Have you ever been convicted of any criminal offense, had adjudication withheld on any criminal offense, pled no contest to any criminal offense or entered into a pre-trial agreement for any criminal offense?	☐ Yes ● No
2. Have you, or any entity, agent, owner, or managing employee ever had disciplinary action taken against any business or professional license held in this or any other state, including licenses issued by the Department of Community Health (GA DCH)?	☐ Yes ● No
3. Has your license to practice ever been restricted, reduced or revoked in this or any other state or been previously found by a licensing, certifying or professional standards board or agency to have violated the standards or conditions relating to licensure or certification or the quality of services provided, or entered into a Consent Order issued by a licensing, certifying or professional standards board or agency?	☐ Yes ● No
4. Have you, or any entity, agent, owner, or managing employee ever been denied enrollment, suspended, excluded, terminated, or involuntarily withdrawn from Medicare, Medicaid or any other government or private health care or health insurance program in any state?	☐ Yes ● No
5. Have you, or any entity, agent, owner, or managing employee ever had payments suspended by Medicare or Medicaid in any state?	☐ Yes ● No
6. Have you, or any entity, agent, owner, or managing employee ever had civil monetary penalties levied by Medicare, Medicaid or other State or Federal agency or program, including GA DCH, even if the fine(s) have been paid in full?	☐ Yes ● No
7. Have Medicare or Medicaid in any state ever taken recoupment actions against you, any entity, agent, owner, or managing employee?	☐ Yes ● No
8. Do you, or any entity, agent, owner, or managing employee owe money to Medicare or Medicaid that has not been paid in full?	● Yes ☐ No
9. Have you ever been convicted under federal or state law of a criminal offense related to the neglect or abuse of a patient in connection with the delivery of any health care goods or services?	☐ Yes ● No
10. Have you ever been convicted under federal or state law of a criminal offense relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance?	☐ Yes ● No
11. Have you ever been convicted under federal or state law of any criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct?	☐ Yes ● No
12. Have you, or any entity, agent, owner, or managing employee been found to have violated federal or state laws, rules or regulations governing Georgia's Medicaid program or any other state's Medicaid program or any other publicly funded federal or state health care or health insurance program?	☐ Yes ● No

N. Certification and Signature

To the best of my knowledge, the information supplied in this document is true, accurate and complete and is hereby released to the Georgia Department of Community Health, Division of Medical Assistance for the purpose of issuing a Medicaid provider number. I understand that falsification, omission or misrepresentation of any information in this enrollment package will result in a denial of enrollment, the closure of current enrollment, and the denial of future enrollment requests, and may be punishable by criminal, civil or other administrative actions. I understand that my signature certifies that I have read the manuals, Parts I, II, and III (if applicable), for the Contract(s) indicated herein and I authorize Medicaid or its authorized representative to verify this information.

Policy Manual Attestation

By signing below, I hereby certify and attest that my staff, agents, credentialing personnel, contractors, subcontractors, billing agent(s) and I have accessed and reviewed the Department of Community Health's policies and procedures manuals including *Part I, Policies and Procedures for Medicaid/PeachCare for Kids®* and the applicable Part II and/or Part III manuals. I understand and acknowledge that the Department's policies and procedures manuals outline the terms and conditions for receipt of medical assistance and participation in the Georgia Medicaid/PeachCare for Kids® program. I understand and acknowledge that my staff, agents, credentialing personnel, contractors, subcontractors, billing agent(s) and I are required to comply with the policies and procedures outlined in *Part I, Policies and Procedures for Medicaid/PeachCare for Kids®* and the applicable Part II and/or Part III policy manuals. I understand and acknowledge that the policies and procedures manuals are amended when the Department finds its necessary or appropriate to do so, and that it is my responsibility as well as the responsibility of my staff, agents, credentialing personnel, contractors, subcontractors, and billing agent(s) to check periodically for any revisions pertaining to the delivery of or reimbursement for services rendered to Medicaid members. I further understand that failure to abide by the Department's policies and procedures will result in adverse actions including, but not limited to, the denial of claims, monetary recoupment, termination, suspension of payments, and reduction of reimbursement. I understand and acknowledge that all of the Department's policies and procedures manuals are accessible through the Departments Medicaid Management Information System (MMIS) web portal at www.mmis.georgia.gov. I certify and attest that I have reviewed the entire contents of the completed application and that the information provided is accurate and complete. I understand that inaccurate, incomplete or omitted data may lead to sanctions against me or my facility."

Information Must Be Entered For The Agreement To Be Processed

Print Name *	Title *
Jeffrey E. Atkinson	CFO, Managing Partner
Signature of Facility Administrator or Authorized Agent *	**Date ***
Jeffrey E Atkinson	1/4/13

* This monetary amount has been addressed with a payment plan through ACS. Will be paid in full by 8/13. Amount is $2,460/Mo.

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All fields marked with * are REQUIRED